# Expenses Entered On MEEX

**KEESM 7532**

You are limited in the types of expenses that can be entered on the **MEEX** screen in KAECSES.

**Spenddown Cases (MS & MA) -** Only four types of medical expenses are to be entered on the **MEEX** screen in KAECSES.

1. Health insurance premiums
   Includes Medicare Part A and Part B premiums not subject to Buy-in, Medicare Part D premiums not subject to Subsidy assistance or portion of premium not covered by Subsidy, Medicare supplemental insurance, other health insurance, and dental insurance. On initial applications, only allow a maximum of two months of Medicare Part A and Part B premiums at first, because you do not know when the spenddown will be met.

2. Due and owing expenses (for a person coded **IN** or **DI** on **SEPA**)
   - Must be incurred outside the base period
   - Unpaid and recipient or legally responsible person living in the home still has the responsibility to pay
   - Monitoring of status and balance of bill is crucial
   - Unpaid verified balance is determined as of the first day of the base period
   - Not already been applied to a base period in which the spenddown was met
   - Unused portion of expense can be carried over to future base periods
   - Unpaid portions of medical expenses on credit cards or loans or referred to a collection agency can be considered as past due and owing
   - Only the principle, no interest and/or late charges, can be applied to the spenddown
   - Documentation of expense is needed

3. Medical expenses for a person coded **DI** on the **SEPA** screen
   - non-disabled, non-aged spouse

4. Nursing facility charges

**NOTE:** For any type of case, only allow the amount of the expense after all TPL coverage has been considered when reducing a spenddown.
**NOTE:** To be allowed against spenddown, items or services must be medically necessary. See KEESM Appendix P-1.
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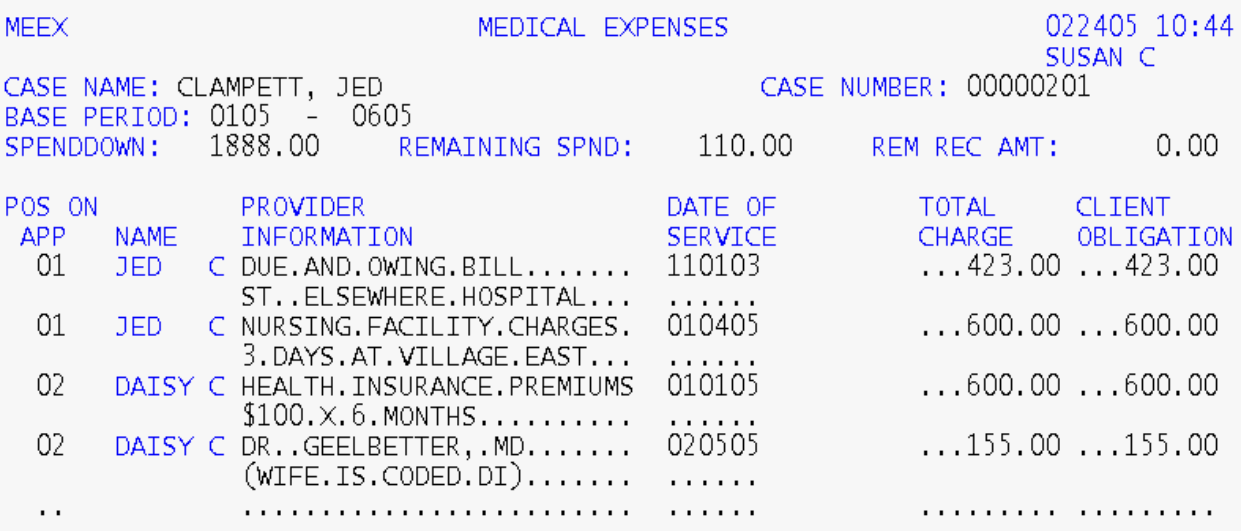
In this image of **MEEX,** you can see each of the four types of medical expenses has been entered as an example for you. Once you enter the **MEEX** expenses and re-authorize the **MSID** and **SPEN** screens, KAECSES will send to the MMIS that night the remaining spenddown amount of $110.00.

Which expenses allowed against a spenddown put the consumer in the best position?

## Allow MEEX Expenses First!



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MEEX                          MEDICAL EXPENSES                    022405 10:44
                                                                  SUSAN C
CASE NAME: CLAMPETT, JED                        CASE NUMBER: 00000201
BASE PERIOD: 0105  -  0605
SPENDDOWN:   1888.00     REMAINING SPND:    110.00     REM REC AMT:      0.00

POS ON          PROVIDER                   DATE OF         TOTAL     CLIENT
 APP   NAME     INFORMATION                SERVICE         CHARGE    OBLIGATION
  01   JED   C  DUE.AND.OWING.BILL.......  110103          ...423.00 ...423.00
                ST..ELSEWHERE.HOSPITAL...  ......
  01   JED   C  NURSING.FACILITY.CHARGES.  010405          ...600.00 ...600.00
                3.DAYS.AT.VILLAGE.EAST...  ......
  02   DAISY C  HEALTH.INSURANCE.PREMIUMS  010105          ...600.00 ...600.00
                $100.X.6.MONTHS.........   ......
  02   DAISY C  DR..GEELBETTER,.MD.......  020505          ...155.00 ...155.00
                (WIFE.IS.CODED.DI).......  ......
  ..            ........................   ......          ......... .........
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- It will benefit the consumer most to have the four types of expenses listed on **MEEX** applied to their spenddown rather than claims that have a potential for provider payment.

- Often you allow the four types of expenses on **MEEX** when you initially establish the six-month base period. The MMIS system receives the remaining spenddown amount. This is the only information on **MEEX,** regarding the spenddown, that is sent from KAECSES to the MMIS. The MMIS system then applies the billed amount to the unmet spenddown amount.

- There may be some situations in which the consumer may submit one of these four types of expenses later in an established base period, this is probably most common with the expenses for spouses or parents coded **DI** on **SEPA**. In order for the spenddown change information to transfer to the MMIS system that night, you will need to **re-authorize the calendar month you are in (or last paid system month)**.

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## Example

Mickey Mantle is approved with a spenddown of $842 for April through September. You allowed Mr. Mantle's health insurance premiums on **MEEX** when the base period was established leaving a remaining spenddown of $332.

In June, Mr. Mantle calls to see if dental expenses for his wife, Merlyn, can be allowed against his spenddown. Merlyn is not elderly or disabled so you encourage Mr. Mantle to send her bills in right away.

June 5th, you receive a fax from a dentist detailing $200 in expenses for Merlyn Mantle. You enter the amount on **MEEX**, and re-authorize June so the information is sent to MMIS. Send the Mantles a notice explaining that his wife's bills have been applied towards the spenddown.

**NOTE:**

✓ In the Mantle's case, if you would not have re-authorized the case, MMIS would not receive the information about the reduced spenddown until the end of June when benefits are paid for the next month. This could have caused additional expenses being applied to the spenddown through the provider or beneficiary billing processes unnecessarily.

## Changing Expenses Listed On The MEEX Screen

- When expenses are entered on **MEEX**, KAECSES sends the remaining Spenddown amount to the interchange MMIS system. The data listed on **MEEX** is **never** sent to the fiscal agent so changes can be made at any time. If changing the expenses listed on the **MEEX** screen negatively impacts the consumer, you must make sure you allow for timely and adequate notice.

**NOTE:**

Anytime a change is processed that effects the remaining spenddown amount you should re-authorize the current month (or last paid month) on KAECSES. Re-authorizing the case ensures that the change is sent to the MMIS system with the daily file and that MMIS reflects the most up to date information about the spenddown.

✓ Spenddown changes and the entire spenddown adjustment process will be discussed later in the training materials.

# Provider Billing Process

The provider billing process **automates** and **simplifies** the spenddown process. The consumer will use their Medically Needy medical card for **all** medically necessary services whether or not they are covered by Medicaid. Providers will be able to electronically check the consumer's remaining spenddown amount. The providers bill the medical card for services rendered and the billed amount is **instantly** applied to the unmet spenddown.

Follow along for a play-by-play description of the provider billing process!

Eligibility Worker ➔ Determines the spenddown on KAECSES, considers if the consumer has any of the four medical expenses that can be allowed on **MEEX**, and notifies the consumer of the remaining spenddown amount. If the spenddown is met or there is no spenddown, the consumer is notified.

KAECSES ➔ Sends the remaining spenddown amount to MMIS (nightly for daily issuance type and monthly for monthly issuance type).

MMIS ➔ Recognizes the Medically Needy (MN) benefit plan and issues a special spenddown medical card to the consumer which reflects the remaining spenddown amount.

Consumer ➔ Receives the spenddown medical card. Takes the card to all medical providers.

Provider ➔ Recognizes the consumer has a spenddown when they see the medical card at the time of service.

**If they are a Medicaid provider**, they are able to check current eligibility information for the consumer via electronic method, automated voice response, or via the internet. Provides the medical service to the consumer and bills the medical service (whether covered or not) to the medical card.

**If they are not a Medicaid provider**, refer to the beneficiary billing process for details about how expenses are applied to the spenddown.

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MMIS ➔ Receives the medical claim. Checks the benefit plan and recognizes the benefit plan to be Medically Needy (MN). Locates the base period(s) for the claim's date of service and identifies the remaining spenddown amount for the base.

**If there is no remaining spenddown**, the claim is either denied or paid according to normal Medicaid processing rules.

**If there is a remaining spenddown**, subtracts the claim's billed amount from the spenddown creating a new remaining spenddown amount.

The MMIS system indicates if the claim has any potential for provider payment (PPP).

**NOTE:** If a claim's date of service spans multiple base periods, the system will apply the correct portion of the expense to each base period.

At the end of each week, MMIS mails the consumer a summary of all expenses applied to their spenddown. This notice reflects the weekly expenses received since the last summary notice was mailed or remaining spenddown amount was received from KAECSES.

When the spenddown is met, MMIS mails the consumer a notice informing them of all expenses used to satisfy their spenddown.

Provider ➔ Receives notice if a claim is paid, denied, or applied to a spenddown. Bills the consumer for the medical service, if applicable.

Consumer ➔ Receives the weekly spenddown notice(s) and keeps them to track their progression toward meeting their spenddown.

When the spenddown is met, they receive the spenddown summary notice and understand which bills are their responsibility to pay, since they were used against the spenddown.

They work with their medical providers on payment of the medical services not covered by Medicaid.

Eligibility Worker ➔ Receives a worker's alert when the spenddown is met. Reviews the claims, within the MMIS system on the Spenddown Claim window, to see if any may be allowed as a Food Stamp medical deduction (if the consumer has an open FS case).

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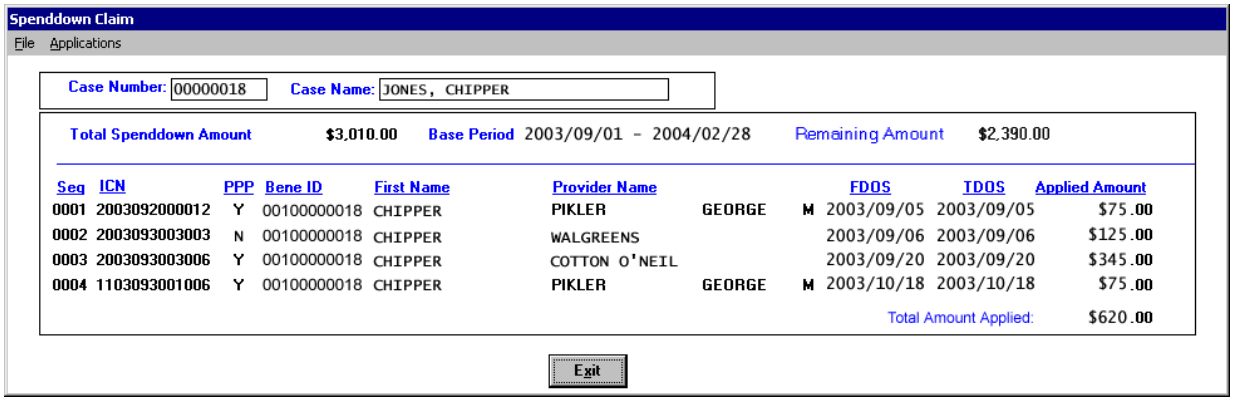
## Medicare Crossover Claims

Medicare and Medicaid share beneficiary eligibility records. This information sharing allows Part A and Part B claims that are billed to Medicare to automatically crossover and be billed to Medicaid as well. The provider does **not** have to take any additional




steps for this process to take place.

The crossover claims received by Medicaid will be applied to the spenddown, if applicable, automatically through the MMIS system. This does not apply to QMB participants because they have additional coverage of the Medicare deductible and co-payments.

If claims are received for a beneficiary, a weekly summary notice is generated to inform a consumer of all expenses received by the MMIS system and applied toward the remaining spenddown amount. This includes Medicare Part A and Part B crossover claims, too.

## Medicaid Providers and Non-Covered Claims

A Medicaid provider will be able to bill the MMIS system for any type of medical service they provide to a consumer. The billed amount for the services is applied to the remaining spenddown through the automated provider billing process. Yes, that even includes services that we all know Medicaid will probably never pay.

Not all services provided by a Medicaid provider will have service codes which are necessary in order for them to bill the expense to MMIS directly. Pseudo procedure codes will be created, and providers will be educated about the use of these codes through their provider manuals and from their local Medicaid Provider Representative.

## Example - Medicaid only

A Medicaid pharmacy will use the appropriate NDC (National Drug Code) for over-the-counter aspirin and bill Medicaid for the costs of the aspirin. This amount will be applied to the remaining spenddown automatically and instantly. The consumer will pay the provider for the aspirin, since they know it is not an expense Medicaid covers. At the end of the week, the consumer receives a summary notice from the MMIS system indicating the costs that were applied to their remaining spenddown.
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**NOTE:** A pharmacy will only bill for an over-the-counter item if they have a doctor's prescription. The consumer will need to obtain a prescription from the doctor and request that the provider bill for these medications. If not, they will have to provide proof of medical necessity, a doctor's statement, and submit a completed Beneficiary/Patient Billing Form in order for the expense to be allowed through the beneficiary billing process. Medicare Part D prescription drug coverage will not cover over-the-counter items. Therefore, it will continue to be applied to the spenddown through the provider or beneficiary billed process.

## Notices Of Spenddown Claim Activity

The MMIS system will generate weekly notices for a beneficiary if a claim is received and applied to their remaining spenddown through the MMIS system. The MMIS will send a spenddown summary notice once the spenddown has been met. If a change occurs and the met spenddown becomes unmet, after a summary notice has been sent, the MMIS system will send the consumer an unmet notice.

The MMIS receives the address of the consumer from KAECSES, and this is where the notices will be sent (FYI: This is the same address the system uses to mail the medical card).

An eligibility worker does not receive a copy or is notified of the weekly or unmet spenddown notices, and will not automatically know about the provider billed claims. A worker can however, use their access to the MMIS system to view the copies of the summary notices sent to the consumer.

You may want to view the MMIS notices before sending a notice to the consumer regarding a change in their spenddown amount. The MMIS notice history tracks the latest communication sent to the consumer regarding the remaining spenddown. This information may be helpful because the information in KAECSES does not reflect claims received and applied to a spenddown through the provider or beneficiary billing processes.

## Example - Medicaid only

Terry Colby is approved for the MS-IL program with a base period of March to August. Based on his income, Terry has a spenddown of $870. The worker allows a due and owing dental bill on the **MEEX** screen reducing the remaining spenddown to $800. This information is received by the MMIS system and it issues Mr. Colby a spenddown medical card.

The first week of March, Terry takes his medical card to his pharmacy, Dillons #67, they bill Medicaid for $89.75 and $240.00 for two prescription refills. Later that week, Terry takes his medical card to a doctor appointment. The doctor's office bills Medicaid $54.00 for an office visit, $100.00 for lab work, and $300 for an EKG test. MMIS applies these charges to the remaining spenddown leaving a balance of $16.25. At the end of the week, MMIS mails Terry a weekly notice to inform him of the charges applied to his spenddown that week and informs him that the balance of $16.25 is remaining on his spenddown.
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Spenddown Weekly Notice

File Edit Applications Options Addtl Options

| Case Number | **01234567** | Case Name: | **COLBY, TERRY** | |
|---|---|---|---|---|

Base Period **2005/03/01 - 2005/09/31** Processed Between Week Start: **2005/03/01** Week End:**2005/03/05**
Date Mailed **2005/03/07** Notice Type **Weekly**
Spenddown Balance Before **$800.00** Spenddown Balance After **$16.25**

| Patient First Name | Provider Name/ Address | From Date of Service | To Date Of Service | Total Billed Amount | Medicare/ Other Insurance Amount | Amount Not Allowed | Amount Used For Spenddown |
|---|---|---|---|---|---|---|---|
| TERRY | Dillons #67<br>102 N Poplar | 2005/03/02 | 2005/03/02 | $89.75 | $0.00 | $0.00 | $89.75 |
| TERRY | Dillons #67<br>102 N Poplar | 2005/03/02 | 2005/03/02 | $240.00 | $0.00 | $0.00 | $240.00 |
| TERRY | Dr. Joe<br>504 E 6th | 2005/03/04 | 2005/03/04 | $54.00 | $0.00 | $0.00 | $54.00 |
| | Dr. Joe<br>504 E 6th | 2005/03/04 | 2005/03/04 | $100.00 | $0.00 | $0.00 | $100.00 |
| | Dr. Joe<br>504 E 6th | 2005/03/04 | 2005/03/04 | $300.00 | $0.00 | $0.00 | $300.00 |

## Continue with our example...

The first week of April, Terry takes his medical card to the pharmacy again. They refill another prescription and bill Medicaid $65.00. MMIS applies $16.25 to the spenddown and pays the remainder of the charge according the Medicaid rules. MMIS sends Terry a spenddown summary notice detailing all of the expenses used to meet his spenddown amount.

Spenddown Summary Notice

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| Case Number | **01234567** | Case Name: | **COLBY, TERRY** | |
|---|---|---|---|---|

Base Period **2005/03/01 - 2005/09/31** Total Spenddown **$800.00**
Date Mailed **2005/04/05** Date Processed **2005/04/05** Notice Type **Summary**

| Patient First Name | Provider Name/ Address | From Date of Service | To Date Of Service | Total Billed Amount | Medicare/ Other Insurance Amount | Amount Not Allowed | Amount Used For Spenddown | Agency Use Payable by MN |
|---|---|---|---|---|---|---|---|---|
| TERRY | Dillons #67<br>102 N Poplar | 2005/03/02 | 2005/03/02 | $89.75 | $0.00 | $0.00 | $89.75 | $0.00 |
| TERRY | Dillons #67<br>102 N Poplar | 2005/03/02 | 2005/03/02 | $240.00 | $0.00 | $0.00 | $240.00 | $0.00 |
| TERRY | Dr. Joe<br>504 E 6th | 2005/03/04 | 2005/03/04 | $54.00 | $0.00 | $0.00 | $54.00 | $0.00 |
| TERRY | Dr. Joe<br>504 E 6th | 2005/03/04 | 2005/03/04 | $100.00 | $0.00 | $0.00 | $100.00 | $0.00 |
| TERRY | Dr. Joe<br>504 E 6th | 2005/03/04 | 2005/03/04 | $300.00 | $0.00 | $0.00 | $300.00 | $0.00 |
| TERRY | Dillons #67<br>102 N Poplar | 2005/0404 | 2005/0404 | $65.00 | $0.00 | $0.00 | $16.25 | $48.75 |

# Beneficiary Billing Process

This process was established for the few times a consumer receives medical services from a non-Medicaid provider. It is also used when a Medicaid provider is unable to bill for a particular service.

## Background For This Process

To maintain the integrity of the claims payment process, a record of the services is kept within the MMIS system to insure duplicate payments are not made. Medical billing has become so complex that it is impossible for accurate records of these claims to be maintained from the minimal information entered on the **MEEX** screen.

A form was created to assist in the collection of all the necessary data elements for medical claims. This form is the Beneficiary/Patient Billing Form (ES-3170). This form is given to the consumer **only** when it is needed. If a medical bill is received and contains all the necessary claim data elements, a form is not necessary as the bill can be entered into the MMIS system right away.

**NOTE:** The majority of medical services are received from Medicaid providers and are applied to the spenddown through the provider billing process.

A play-by-play description of the beneficiary billing process!

Eligibility Worker ➔ Establishes the spenddown on KAECSES, considers if the consumer has any of the four medical expenses that can be allowed on **MEEX**, and notifies the consumer of the remaining spenddown amount.

KAECSES ➔ Sends the remaining spenddown amount to MMIS (nightly for daily issuance type and monthly for monthly issuance type).

MMIS ➔ Recognizes the Medically Needy (MN) benefit plan and issues a special spenddown medical card to the consumer which reflects the remaining spenddown amount.

Consumer ➔ Receives the spenddown medical card and takes the card to all medical providers. If a provider does not accept Medicaid, asks their worker how the expense can be allowed on their spenddown.

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Eligibility Worker ➔ When they become aware of an incurred medical expense that must be applied to the spenddown through the beneficiary billing process, they send the consumer an ES-3170, Beneficiary/Patient Billing Form. This form is used to obtain the necessary claim information in order to enter the expense into the MMIS system.

Consumer ➔ Asks their medical provider to complete the ES-3170 they receive from their eligibility worker.

Provider ➔ Recognizes the consumer has a spenddown and completes the ES-3170 Beneficiary/Patient Billing Form, so that their medical services can be applied to the spenddown amount. Returns the completed form to either the consumer or the area SRS office.

Consumer ➔ Submits the completed ES-3170 form to their eligibility worker.

Eligibility Worker ➔ Receives the completed ES-3170 from either the provider or the consumer and reviews the form to make sure all necessary data is provided.

Uses their MMIS access to see if the consumer holds any TPL policies. You will learn how to access the TPL information in the MMIS system training that will be presented by fiscal agent staff.

If TPL exists, the worker must verify that the Third Party Liability is resolved for each medical service listed on the form. If the TPL payments are outstanding, the eligibility worker should hold the form or return it to the consumer until TPL payments are completed.

**If the self-bill form is not complete**, the worker returns the form to the consumer with an explanation of what data is needed or they call the provider to resolve the discrepancy.

**If the self-bill form is complete**, ensures that the expense is not one of the four things that are to be entered on the **MEEX** screen then enters the information about the beneficiary billed claim on the Beneficiary Spenddown Claim window in the MMIS system. You will learn how to complete this screen in the MMIS system training to be provided by fiscal agent staff.

MMIS ➔ Tracks expenses applied to the spenddown through the beneficiary and provider billing processes and sends the consumer a weekly notice informing them of the expenses applied to their spenddown. and the remaining spenddown amount. If the expenses meet the spenddown then a summary notice is sent.

Consumer ➔ Receives the weekly notice(s) and keeps them to track their progression toward meeting the spenddown.

When the spenddown is met, they receive the spenddown summary notice and understand which bills are their responsibility to pay, since they were used against the spenddown.

They work with the providers on payment of the medical services not covered by Medicaid.

Eligibility Worker ➔ The EES worker will receive an alert when the spenddown is met. Review the claims, within the MMIS system on the Spenddown Claim window, to see if any may be allowed as a Food Stamp medical deduction (if the consumer has an open FS case).

## Medicaid Providers & Beneficiary Billing Process

There may be **rare** occasions where the beneficiary billing process is used for claims received from a Medicaid provider. Providers are not required to bill Medicaid if a card isn't presented at the time of service. The recommendation is to pursue the provider billing method first, then use the beneficiary billing process for these claims when necessary.

## Stop Entering BB Claims Once The Spenddown Is Met

The MMIS system will allow you to continue entering BB claims even though a spenddown is already met. You want to make sure you stop entering claims once the spenddown is met.

- If the consumer has additional expenses that are their responsibility to pay, go ahead and have them complete the ES-3170 form and file it in their case file. The information will be on hand for you to use as due and owing (if applicable) on future base periods or you can use if you are making a change which is increasing the spenddown amount.

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## Errors Made Entering BB Claims

Eligibility workers will enter beneficiary billed claims into the MMIS system through the Beneficiary Spenddown Claim window. If you determine that a mistake was made entering the claim (e.g., claim has been entered in error, applied amount is wrong, TPL was not resolved before entering, or incorrect date of service), the claim must be voided and reentered. You will learn how to void incorrect BB claims in the MMIS training to be presented by fiscal agent staff.

## BB Claims and Part D

Medicare Part D cost-sharing will not be provider billed. The consumer will need to submit Part D co-pays to the eligibility worker to apply toward the spenddown through the beneficiary billed process. Remember Part D premiums or partial premiums will be applied to the MEEX screen.